HCFA CONTRACT* 500-93-0016/WA 313
97-231
97-231-01-TJN

not there

Medicaid Managed Care Project

Final Report

March 31, 1999

Delivered in accordance with
Contract Number 500-93-0016
Work Assignment Number 313
Deliverable 7.2

Table of Contents

Section 1: Executive Summary 1
Background / Purpose 1
Analysis of Information Gathered 2
Conclusions / Recommendations 2
State Questions and Answers 2
State Statistics 3

Section 2: Background / Purpose 4
Reasons for Project 4
Sources of Data 5
Method for Selecting States to Participate in Project 7
Process Used to Gather Information 11

Section 3: Analysis of Information Gathered 15
Current Sources of Complete and Consistent Data 15
Defining and Collecting Plan Data for Researchers and Policy Analysts 17
Collecting Accurate Data on Enrolled Populations in Managed Care 18
Capturing Complete and Consistent Managed Care Utilization Data 19

Section 4: Conclusions / Recommendations 20
Preface: 1999 MSIS Enhancements and Changes 20
Recommendations for Improving Data Quality and Reporting 23
The Future of MMCER 24
Lessons Learned 24

Appendix A: Responses to State Questionnaires 25
CALIFORNIA - Response to Questionnaire 26
DELAWARE - Response to Questionnaire 28
MICHIGAN - Response to Questionnaire 33
MINNESOTA - Response to Questionnaire 34
NEW JERSEY - Response to Questionnaire 39
PENNSYLVANIA - Response to Questionnaire 46
WISCONSIN - Response to Questionnaire 54

Appendix B: Other State Questionnaires 60
ALABAMA Questionnaire 61
ARIZONA Questionnaire 65
COLORADO Questionnaire 68
FLORIDA Questionnaire 73

MISSOURI - Response to Questionnaire 81
UTAH Questionnaire 85
VERMONT Questionnaire 89
WASHINGTON Questionnaire 92

Appendix C: State Statistics 105
ALABAMA 106
ARKANSAS 107
CALIFORNIA 108
COLORADO 109
DELAWARE 111
FLORIDA 112
INDIANA 117
IOWA 118
MICHIGAN 150
MINNESOTTA 151
MISSOURI 155
NEW JERSEY 157
PENNSYLVANIA 160
TENNESSEE 162
UTAH 163
VERMONT 164
WASHINGTON 165
WISCONSIN 170

Section 1: Executive Summary

Background / Purpose

During recent years, there has been a shift in health care coverage for State Medicaid populations from traditional fee-for-service to a wide variety of Managed Care models. Because certain types of data for Managed Care enrollees is often missing or incomplete in our current statistical environment, this shift has led to major problems for researchers who study the Medicaid program.

The purpose of this project is to examine, on a state-by-state basis, current data collection problems and to recommend solutions to these problems. To do this, the project group had to answer the following questions :

- Of the data currently captured, which is the most complete and consistent?
- How do we clearly define and collect data for the different types of Plans that are important to researchers and policy analysts?
- How can we collect accurate data on enrolled populations in Managed Care?
- How can we develop a system that captures complete and consistent data on utilization for enrollees in Managed Care?

Three sources of data were used as input to addressing these questions:

- **Medicaid Statistical Information System (MSIS)**: This is an automated system developed and maintained by HCFA which is used for gathering Medicaid data in a standard format from the various states participating in MSIS.
- **Medicaid Managed Care Enrollment Report (MMCER)**: This report is compiled and published by HCFA. It is a summary of Managed Care enrollment by state and, within state, by Plan.
- **State List of Plans**: The third data source used were listings identifying each Plan operating in a state by the Plan name and state-assigned provider identification number.

States were selected to participate in the project based on MSIS participation, as well as on the following factors:

- Range of waiver types
- Size of population served
- Range of Managed Care Plan types
- Geographic distribution of Managed Care Plans within the State

- Anticipated responsiveness
- Known quality of data based on the Medicaid Managed Care Enrollment Report (MMCER) and the National Summary of State Medicaid Managed Care Programs information.

The process used to gather information for the project included the following six phases (described in detail in Section 2):

- Analysis of Eligible File
- Analysis of CLAIMOT File
- Analysis of MMCER Utilization data
- Statistical consolidation process
- Preparation for State interviews
- Conducting State interviews

Analysis of Information Gathered

Conferences were conducted with seven states during the course of the project: California, Delaware, Michigan, Minnesota, New Jersey, Pennsylvania, and Wisconsin. Section 3 contains the project team's findings, based on these conferences, about best current sources of complete and consistent data, methods for defining and collecting Plan data for researchers and policy analysts, methods for collecting accurate enrollment data, and strategies for capturing complete and consistent utilization data.

Conclusions / Recommendations

After performing an analysis of the information gathered, the project team formulated recommendations for improving data quality and reporting and offered conclusions concerning the future of MMCER and lessons learned during the project. Section 4 also includes a preface that contains a detailed outline of 1999 MSIS Enhancements and Changes

State Questions and Answers

Appendix A contains the specific questions drafted for each state that participated in the project, as well as the answers provided by these states. Appendix B contains questions developed for states that were potential participants in the Medicaid Managed Care Project, but who were unable to participate.

State Statistics

Appendix C contains two separate tables for each of the states that were considered for inclusion in the project. Table 1 for each state was created from the eligibility data, the total number of premium payments derived from the CLAIMOT file, and the number of Managed Care beneficiaries from the MMCER. Each table contains the following data:

- HMO Indicator (category)
- Number of beneficiaries by category
- Percentage of total beneficiaries by category
- Cumulative number of beneficiaries in ELIGIBLE file
- Cumulative percentage of beneficiaries to the total
- Total Managed Care beneficiaries excluding those in category "000"
- Total number of premium payments (CLAIMOT file)
- Total MMCER beneficiaries

Table 2 for each state was created using data from the CLAIMOT file and contains:

- Provider/Plan identification number
- Number of premium payments (Frequency)
- Percentage of premium payments to the total
- Cumulative premium payments
- Cumulative percentage (CUMFREQ)

Section 2: Background / Purpose

Reasons for Project

During recent years, there has been a shift in health care coverage for State Medicaid populations from traditional fee-for-service to a wide variety of Managed Care models. Because certain types of data for Managed Care enrollees is often missing or incomplete in our current statistical environment, this shift has led to major problems for researchers who study the Medicaid program.

For enrollees in fully prepaid Plans, for example, the data typically contain monthly claims for premium payments. Claims for premium payments and fee-for-service claims for out-of-scope services exist for enrollees in partially prepaid Plans. For PCCM enrollees, the data may contain claims for case management fees as well as fee-for-service claims. However, regardless of the type of Plan, the status of reporting on patient encounter data was largely unknown at the start of this project.

Because such a variety of Plans are in operation at the state level, an accurate analysis of enrollee characteristics cannot be made until a method is developed for identifying the type of Plan or Plans that cover each enrollee. Furthermore, we cannot understand the utilization of Medicaid services for persons in prepaid Plans until we establish a method for compiling accurate, complete encounter data for individual enrollees regardless of their type of coverage. While compiling this data is not a problem within a fee-for-service model that produces retrospective claims for services rendered, it represents a serious challenge within the context of the current Plan environment.

The purpose of this project is to examine, on a state-by-state basis, the data collection problems outlined above. As a first step in identifying solutions to these problems, the project group must answer the following questions :

- Of the data currently captured, which is the most complete and consistent?
- How do we clearly define and collect data for the different types of Plans that are important to researchers and policy analysts?
- How can we collect accurate data on enrolled populations in Managed Care?
- How can we develop a system that captures complete and consistent data on utilization for enrollees in Managed Care?

Where solutions to these problems are apparent, they will be recommended. In areas where further investigation is required, suggestions for the direction of this investigation will be recommended.

Sources of Data

There were three sources of data used in this study. Below is a summary description of each.

- **MEDICAID STATISTICAL INFORMATION SYSTEM (MSIS)**: This is an automated system developed and maintained by HCFA which is used for gathering Medicaid data in a standard format from the various states participating in MSIS. The data are supplied in electronic form by the state Medicaid agencies and validated through procedures developed by HCFA. State participation in MSIS was voluntary through the 1998 data year and required starting in 1999 by enactment of the 1997 Balanced Budget Act.

  The data component of the system is comprised of the six following files:
  - Personal Summary file
  - Eligible file
  - In-Patient Claim file
  - Long-Term Care Claim file
  - Prescription Drugs Claims file
  - Other Therapeutic and Diagnostic Services file

  Of these, only the Eligible file and the Other Therapeutic and Diagnostic Services (CLAIMOT) files were used for this project.

  The HMO indicator and the MSIS beneficiary identification number were the two data elements used. The HMO indicator in the Eligible file is a code indicating whether a beneficiary was enrolled in an HMO, Prepaid Health Plan (PHP), or other capitation Plan during the month. Following is a list of the HMO indicators: Code Values:

  000 Not eligible for Medicaid
  001 Eligible, was not enrolled in a private HMO, PHP, or other capitation Plan
  100 Eligible, was enrolled in a private HMO with coverage purchased by the state
  200 Eligible, was enrolled in a private PHP with coverage purchased by the state
  500 Eligible, was enrolled in an other capitation with coverage purchased by the state
  600 Eligible, was enrolled in a private HMO with coverage purchased by a third party
  700 Eligible, was enrolled in a PHP with coverage purchased by a third party
  800 Eligible, was enrolled in another capitation with coverage purchased by a third party
  900 Invalid or missing information

  The total HMO enrollment for the state, based on the MSIS Eligible file, was taken as the sum of the counts accumulated for each of the HMO indicators "100" through "800."

Premium payment data was obtained from the CLAIMOT files for the second and third quarters of 1997. The data retrieved was restricted to June by using the beginning and ending dates of service (it was necessary to use six months of data because MSIS premium payments are submitted based on the date processed rather than the date of service). The number of premium payments made was determined by counting all those recipients with a type-of-service indicator equal to "20." The type of service indicator is a numeric code carried in each record and specifies the kind of service for which the Plan is being billed. A value of "20" indicates a premium payment for an HMO, HIO, or other prepaid health Plans.

- **MEDICAID MANAGED CARE ENROLLMENT REPORT (MMCER)**: This report is compiled and published by HCFA. It is a summary of Managed Care enrollment by state and, within state, by Plan. The data are provided by state Medicaid agencies to the HCFA Regional Offices. It is compiled and aggregated by the HCFA Data and Systems Group.

  This study used the MMCER state summary enrollment and the detailed enrollment by Plan within the states as of June 30, 1997. These figures were compared to the number of enrollments and the number of premium payments as reflected in the MSIS files for the same period.

- **STATE LIST OF PLANS**: The third data source used were listings identifying each Plan operating in a state by the Plan name and state-assigned provider identification number. The lists were supplied by each state in the study and are referred to as the "crosswalk." The list served as a cross-reference between the MMCER publication and the MSIS CLAIMOT file. The Plan name was used to obtain Plan enrollment figures from the MMCER publication, and the associated provider number was used to retrieve premium payments as recorded in the CLAIMOT file. This allowed a comparison of enrollment and premium payments to be made between the two sources. Only the states agreeing to be interviewed were asked to provide the crosswalk.

Method for Selecting States to Participate in Project

The first criterion used to select States for analysis was participation in MSIS. Non-MSIS states lacked the consistent enrollment and utilization data we needed for comparison to MMCER data. MSIS states were selected to participate in the project based on the following factors:

- Range of waiver types
- Size of population served
- Range of Managed Care Plan types
- Geographic distribution of Managed Care Plans within the State
- Anticipated responsiveness
- Known quality of data based on the Medicaid Managed Care Enrollment Report (MMCER) and the National Summary of State Medicaid Managed Care Programs information.

The initial states selected included:

1. **Alabama**
   - Three 1915(b)s and 1115 waiver types
   - HMO, PCCM and PHP
   - Large proportion of enrollees were covered by Managed Care
   - Programs (waivers) cover counties
2. **Arkansas**
   - One 1915(b)s
   - PCCM
   - Large proportion of enrollees were covered by Managed Care
   - Programs (waivers) cover state
3. **California**
   - Ten 1915(b)s, four 1115 waiver types and voluntary program
   - HMO, HIO, PCCM and PHP
   - Large proportion of enrollees were covered by Managed Care
   - Programs (waivers) cover counties
4. **Colorado**
   - Two 1915(b)s
   - HMO, PCCM and PHP
   - Large proportion of enrollees were covered by Managed Care
   - Mental health program (waiver) covers specific counties and the other program provides integrated service statewide.
5. **Delaware**
   - 1115 waiver
   - HMO

- Large proportion of enrollees were covered by Managed Care
- Programs (waivers) cover states

6. **Florida**
   - Two 1915(b)s, voluntary program (no authority)
   - HMO, PCCM and PHP
   - Large proportion of enrollees were covered by Managed Care
   - Mental health program covers specific counties with other programs cover statewide
7. **Indiana**
   - 1915(b)
   - HMO and PCCM
   - Only TANF/TANF-Related and ward and foster children
   - Programs (waivers) cover states
8. **Iowa**
   - Three 1915(b)s
   - HMO, PCCM and PHP
   - Large proportion of enrollees were covered by Managed Care
   - Mental health and substance abuse programs (waiver) are statewide. The other programs cover specific counties
9. **Michigan**
   - Two 1915(b)s and voluntary program
   - HMO, PCCM and PHP
   - Large proportion of enrollees were covered by Managed Care
   - Programs (waivers) cover statewide
10. **Minnesota**
    - One 1915(b)s and 1115(a) waiver types
    - HMO
    - Large proportion of enrollees were covered by Managed Care
    - Mental health and substance abuse programs (waiver) are statewide. The other programs cover specific counties
11. **Missouri**
    - 1915(b) waiver type
    - HMO
    - Only TANF/TANF-related and children under legal custody DSS
    - Programs (waivers) covers specific counties and cities

12. **New Jersey**
    - 1915(b) waiver type
    - HMO
    - Large proportion of enrollees were covered by Managed Care
    - Programs (waivers) cover state

13. **Pennsylvania**
    - Four 1915(b)s waiver types and voluntary program
    - HMO, PCCM and PHP
    - Large proportion of enrollees were covered by Managed Care
    - Programs (waivers) cover counties
14. **Utah**
    - 1115 waiver type
    - HMO, PCCM and PHP
    - Large proportion of enrollees were covered by Managed Care
    - Programs (waivers) cover state
15. **Vermont**
    - 1115 waiver type
    - HMO
    - Only TANF/TANF-Related and extended eligible to age 21-65
    - Programs (waivers) cover state
16. **Washington**
    - Two 1915(b)s waiver types
    - HMO, PCCM and PHP
    - Large proportion of enrollees were covered by Managed Care
    - Programs (waivers) cover state
17. **Wisconsin**
    - 1915(b) waiver type and voluntary programs
    - HMO and PHP
    - Large proportion of enrollees were covered by Managed Care
    - 1915(b) programs (waiver) statewide with the voluntary programs cover specific counties

The final selection and prioritization of the states to be interviewed were derived from the list of initial states selected, after conducting a preliminary analysis of the MSIS Eligibility and Utilization /Claims data. These states and the evaluation criteria used to select them are listed in the chart that follows.

FINAL LIST OF STATES TO BE INTERVIEWED			
STATE	**PREMIUM PAYMENTS**	**DUMMY CLAIMS**	**REASONS TYPES OF MC**
Alabama +	No	Yes	HMO, PHP and PCCM
California	Yes	Yes	All types of MC Plans
Colorado	Yes	No	HMO, PHP and PCCM
Delaware +	Yes	No	HMO
Florida	Yes	No	HMO, PHP and PCCM
Indiana .	Yes	Yes	HMO and PCCM
Iowa +	Yes	Yes	HMO, PHP and PCCM
Michigan	Yes	No	HMO, PHP and PCCM
Minnesota	Yes	No	HMO
Missouri	Yes	Yes	HMO
New Jersey +	Yes	Yes	HMO
Pennsylvania	Yes	No	HMO, PHP and PCCM
Utah	No	No	HMO, PHP and PCCM
Vermont	Yes	No	HMO
Washington	Yes	No	HMO, PHP and PCCM
Wisconsin	Yes	No	HMO and PHP

+ Initial states to be interviewed

The remaining states were not considered because of the special 1115 Waiver demonstrations as well as some were solely PCCM or because of state size and/or missing data.

Process Used to Gather Information

The data maintained in MSIS provided the detail used in the initial portion of the study and were extracted using the proprietary statistical analysis program SAS. The following describes the process employed with each of the identified sources.

- **ELIGIBLE FILE PROCESS**:

  1. The MSIS enrollee identification number and the HMO indicator for June, 1997 were extracted from the enrollment record in the Eligible File.
  2. The extracted data were sorted by MSIS identifier to eliminate duplicate occurrences of the MSIS identification number.
  3. A frequency distribution of MSIS identification numbers based on the HMO indicator in each eligibility record was performed.

  The above process produced a tabulation of the number of unique IDs (e.g. Managed Care beneficiaries) in each HMO category. This process was repeated for each of the twenty-nine states which contribute data to the MSIS program.

- **CLAIMOT FILE PROCESS**:

  1. All claims records for the second and third quarters of 1997 having a type-of-service value equal to "20" (premium payment) and a service period encompassing June, 1997 were extracted.
  2. The extracted data was tabulated to show the number of Medicaid enrollees for whom premium payments were made to Managed Care Plans.

  This process was also repeated for each state providing data to MSIS. The result shows the total number of premium payments made by the state as of June, 1997. In addition, a distribution of the number of premium payments made to each Managed Care Plan in the state was formulated on the basis of the provider/Plan identifier present in the CLAIMOT records.

- **MMCER UTILIZATION PROCESS:** The total number of Managed Care beneficiaries in each Plan reported by the state was manually extracted from the MMCER for purposes of comparison with the MSIS data.

- **STATISTICAL CONSOLIDATION PROCESS**: The statistical information created in the preceding steps was consolidated for use in the following manner.

  The tables created from the eligibility data, the total number of premium payments

derived from the CLAIMOT file, and the number of Managed Care beneficiaries from the MMCER report were incorporated into an Excel spreadsheet. These tables are included in Appendix C (see Table 1 for each state). Each table contains the following data:

- HMO Indicator (category)
- Number of beneficiaries by category
- Percentage of total beneficiaries by category
- Cumulative number of beneficiaries in ELIGIBLE file
- Cumulative percentage of beneficiaries to the total
- Total Managed Care beneficiaries excluding those in category "000"
- Total number of premium payments (CLAIMOT file)
- Total MMCER beneficiaries

A second set of tables was created using data from the CLAIMOT file. These tables are also included in Appendix C (see Table 2 for each state). Each of these tables contains the following data:

- Provider/Plan identification number
- Number of premium payments (Frequency)
- Percentage of premium payments to the total
- Cumulative premium payments
- Cumulative percentage (CUMFREQ)

Using the information in Tables 1 and 2, comparisons were made between Plan enrollment, the number of premiums paid to the Plan, and the enrollment shown on the MMCER state Plan summary page.

A series of specific questions resulting from the above comparisons were combined with questions of a more general nature regarding Managed Care in the state. In general the questions addressed the following issues:

- Reconciliation of: MSIS eligibility and premium payments and between MSIS and MMCER total Managed Care enrollment
- Primary Care Case Management Plans (PCCM) where applicable
- Methods used to collect Medicaid enrollment and encounter data
- What state data systems supply data to MSIS
- Future Plans
- How Medicaid data is processed in the state.

- **PREPARATION FOR STATE INTERVIEW**

  1. A draft of tabulations and questions tailored to the types of Managed Care models in each state was provided to HCFA for review.

  2. HCFA and DCCA jointly contacted each state, requesting their participation in the study.

  3. Those states agreeing to participate were asked to supply a listing which gave the provider name and the corresponding provider identification number (cross-walk).

  4. The cross-walk and information from the CLAIMOT summary (Table 2) were combined to create the Plan Identification Comparison table that included the following data:
     - Provider/Plan name
     - Provider Identification Number
     - Number of Premium Payments (from CLAIMOT file)
     - MMCER Plan enrollment

     Question marks were used to indicate missing provider/Plan names or identification numbers.

  5. Upon review by HCFA and subsequent revision of the questions a package was sent to each participating state containing:
     - Final draft of questions
     - Comparison tables generated by DCCA
     - MMCER statistics
     - National Summary of State Medicaid Managed Care Programs statistics

  6. After giving each state an opportunity to review their package, a conference call or site visit was scheduled.

- **STATE INTERVIEWS**: While it was our desire to schedule face-to-face visits with states whenever possible, budgets and schedules limited our on-site visits to Pennsylvania, Delaware, and New Jersey. Conference calls were held with California, Michigan, Minnesota, and Wisconsin. In general, the interviews were conducted in the following format:

  - The Federal Government Task Leader (GTL) opened each meeting, stating its explicit purpose was to acquire information regarding the current and future operation of the state Managed Care program and its relationship to MSIS, reconcile the statistics resulting from study, and to assure the state that no

additional mandates would be placed on the state as a result of the interview.

- The questions pertaining to any differences between enrollment and Managed Care premium payments as reflected in the MSIS and MMCER were then addressed.
- The meeting continued with the general questions found in Section 3 of the questionnaire.
- The interview concluded with discussion of other items of interest from Section 4 of the questionnaire.

Appendix A contains the specific questions drafted for each state as well as the answers the state provided.

Section 3: Analysis of Information Gathered

Current Sources of Complete and Consistent Data

During the period of this effort, there were nineteen states scheduled to be contacted; they are:

Alabama	Florida	New Jersey
Arizona	Indiana	Pennsylvania
Arkansas	Iowa	Tennessee
California	Michigan	Utah
Colorado	Minnesota	Vermont
Delaware	Missouri	Washington
		Wisconsin

Enrollment statistics between MSIS eligibility, the premium payments and the MMCER were developed for the nineteen states in addition to the initial questionnaires. Three of the nineteen states declined participation in the project; we were unable to contact the appropriate technical representatives in three other states. For six other states, production schedules and priorities at both the state and federal level made it impractical to schedule conferences before the project deadline. However, enrollment comparisons and questions have been prepared for these states so that conferences can be scheduled at a later date, if desired.

The seven states listed below were able to accommodate our request for an interview or site visit:

California	Conference call and site visit
Delaware	Site visit
Michigan	Conference call
Minnesota	Conference call
New Jersey	Site visit
Pennsylvania	Site visit
Wisconsin	Conference call

Based on the information gathered using the process described in Section 2, Delaware, Wisconsin, and New Jersey were identified as having the most reliable and consistent enrollment and premium payment claims data. This conclusion is based on the following common findings in these three states:

- First, there is good agreement between the enrollment data and claims data in the form of premium payments as reflected in the MSIS files.
- Second, the number of recipients enrolled in Managed Care (as shown by the MSIS

eligibility file) compares favorably to the MMCER publication when the adjustments as specified in Appendix A and timing issues are taken into consideration. New Jersey enrollment data exhibited a high degree of consistency among the sources used. Managed Care enrollment indicated by the MSIS eligibility data was within 0.5% of that in the MMCER publication. This indicates reasonably accurate enrollment data.

- Last, all three states had Plans and schedules to obtain and process encounter data through MSIS as well as anticipating methods of determining the quality and completeness of the encounter data.

While many factors contributed to the reliability and consistency of the data in these states, several were of particular interest to the project team:

- In comparison to other states interviewed, these states had a limited number of Plan types.
- Individuals in these states could be covered by only 1 Managed Care Plan at a time.
- The majority of the Medicaid population in the state was enrolled in Managed Care.
- Geographic distribution of Plans within the state was less complex compared to other states.
- These states had clear, concise contractual arrangements with their Managed Care Plans.

The remaining four states interviewed could not provide a complete explanation for the differences between enrollment data sources, but did provide significant insight into their current operation. Two of the states recommended the use of the MSIS HMO indicator as the source of the most accurate count of Managed Care enrollees for their state. They also shared information on anticipated changes that may occur with the 1999 MSIS activity (see Appendix A).

It was abundantly evident that there is a significant difference between visiting the state and conducting the interview by means of a conference call. For those states visited, questions regarding the data were quickly resolved. Plans for acquiring additional claims data and the attendant problems were discussed openly. These direct meetings helped to established a high degree of confidence in the methods employed by these states to collect and manage the data.

For the states which did not participate in the study, enrollment reports and questionnaires are included in Appendix B. These products can be used at a later time.

Defining and Collecting Plan Data for Researchers and Policy Analysts

The opportunity for research and the formulation of Managed Care policy based on data currently maintained in the MSIS files is limited. First, prior to the 1997 Balanced Budget Act, supplying data to MSIS was voluntary and only twenty-nine states elected to participate in the program. Of the states participating, enrollment data were not consistent among sources reporting to HCFA within the same state. Also, there was very little encounter data. Under the rules for supplying data to MSIS for the years preceding 1998, states were limited by MSIS coding standards to using a single premium payment classification (regardless of how many state codes existed) when defining the operation of Plans within the state. Our experience with states has taught us that there is no reliable single source of data for classifying enrollment in Medicaid Managed Care programs. In some states, eligibility statistics are an accurate indicator of enrollment; in other states, premium payments are the only accurate measure of enrollment.

Several factors indicate that there is increased potential for data added to MSIS for 1998 and subsequent years which will be capable of supporting health care analysis and any resulting policy. Passage of the Balanced Budget Act will require all states to submit Medicaid enrollment and claims data including Managed Care encounter services for claims processed after 1/1/1999. The 1998 MSIS specification for collecting the data provides more reporting options to the states, allowing greater accuracy when describing the form and operation of heath Plans in their respective states. For example, the coding structure for type-of-service provides three premium payment classifications for fiscal year 1998:

"20" Capitated Payments to HMO or HIO Plan
"21" Capitated Payments to Prepaid Health Plans (PHPS)
"22" Capitated Payments for Primary Care Case Management (PCCM)

The Balanced Budget Act, the potential for increased volumes of data, and the need to perform analysis and formulate policy based on the data all add impetus to ensuring the quality of the data. In addition to the current opportunity to address the issues of accuracy and completeness of the data, there is an awareness of the need for those supplying and using the data to have a clear understanding of its definition, limitations, and appropriate uses. However, there is a continuing need to monitor the reporting to the MSIS system through other sources in order to maintain the quality and completeness of the data.

Collecting Accurate Data on Enrolled Populations in Managed Care

Based on information from HCFA and the states, and our analysis of enrollment data, the project team believes that collection of accurate Managed Care enrollment will be a gradual process. In view of the complexity of the information being sought and the resources available to oversee the process, we recommend a measured approach. Initially, there will have to be a concentrated effort to assist the states in meeting the data collection requirements defined in the MSIS specification for 1999. This initial effort needs to be followed by a period of assessment.

The assessment will determine the accuracy of the data as well as the ability of the states to meet the MSIS specification. The assessment period should also include the opportunity to take suggestions for improving the system and finding ways to add to its value to the states. Reducing state reporting requirements or providing data useful to the states will help ensure their cooperation and result in a better information system. Once these initial efforts are complete, a maintenance period can commence during which the system and data undergo scheduled review for utility and efficiency.

Several of the recommendations to be found under that section also address this issue. Among them, the realization that maintaining effective communication among the Plans, the participating states, and HCFA is critical to the success of making MSIS a reliable source of information. Staged implementation of the MSIS collection under the new rules for collection and a measured approach to assessing the quality of the data beginning with enrollment numbers are requirements for improving its quality.

Capturing Complete and Consistent Managed Care Utilization Data

The analysis performed on the MSIS claim files shows no consistent or complete Managed Care utilization (encounter) data being supplied by the states. The states that were interviewed stated that it is difficult to obtain utilization data from the Plans participating in Managed Care and that there is no current statutory requirement to report utilization to the state. However, the 1997 Balanced Budget Act requires that the states supply encounter data to HCFA by January, 1 1999. During the interviews some of the states indicated that they would not be able to comply with this requirement until 2000 or 2001.

Several states made reference to their interest in obtaining these data and described several approaches being taken. Delaware is planning to introduce risk-adjustment as an economic incentive to the Plans for this purpose. They are also conducting medical audits to ascertain the accuracy of the data reported. Other states are planning alternative methods for the same purpose. New Jersey is attempting to make some determination regarding the accuracy of the utilization data through the use of benchmarks (based on historical fee-for-service and Managed Care Plan data). California is conducting financial audits to assess the completeness and accuracy of their encounter data. Of these, the risk-adjustment approach taken by Delaware appears to hold the most promise.

Delaware, New Jersey, and Wisconsin have included provisions for sanctions to be applied against Plans that do not provide the data. However, these sanctions are very difficult to enforce and the states are seeking additional measures to make them more enforceable. The State/Plan contracts that were reviewed as part of this study (Delaware, etc.) require the reporting of Managed Care utilization data to the MMIS. It should be noted that Utah does not process premium payments through claims; premiums are paid on a roster basis.

Finally, the remarks concerning the accuracy and use of enrollment data pertain to utilization data as well. In addition, the volume of added encounter utilization data promises to be significantly greater than current fee-for-service utilization data. This added volume comes with its own management requirements and presents additional challenges when attempting to remedy problems discovered after large amounts of data have been added to the system.

Section 4: Conclusions / Recommendations

Preface: 1999 MSIS Enhancements and Changes

In the 1997 MSIS, the only data element available for identifying Managed Care enrollment statistics was an HMO Indicator with the following values:

Value	Definition
000	Not eligible for Medicaid
001	Eligible, was not enrolled in a private HMO, PHP, or other capitation Plan
100	Eligible, was enrolled in a private HMO with coverage purchased by the state
200	Eligible, was enrolled in a private PHP with coverage purchased by the state
500	Eligible, was enrolled in an other capitation with coverage purchased by the state
600	Eligible, was enrolled in a private HMO with coverage purchased by a third party
700	Eligible, was enrolled in a PHP with coverage purchased by a third party
800	Eligible, was enrolled in another capitation with coverage purchased by a third party
900	Invalid or missing information

Changes will be made to the MSIS (effective 1-1-1999) to enable the capture of enrollment data elements that will identify Medicaid Managed Care enrollees more accurately and categorize them by type of Plan. This expanded data collection requirement, combined with the recommendations in this report could ultimately relieve the burden of the manual collection of enrollment data for MMCER that is currently performed by the State and HCFA Regional offices. The new MSIS data elements include:

- **BASIS-OF-ELIGIBILITY**: This code indicates the reason for an individual's eligibility as of the last day of the month referenced.

Value	Definition
0	Individual was not eligible for Medicaid at any time during the month
1	Aged Individual
2	Blind/Disabled Individual
3	Not used
4	Child (not Child of Unemployed Adult, not Foster Care Child)
5	Adult (not based on unemployed status)
6	Child of Unemployed Adult (optional)
7	Unemployed Adult (optional)
8	Foster Care Child
9	Eligibility status Unknown (counts against error tolerance)

- **DUAL-ELIGIBLE-FLAG**: This code indicates coverage for individuals with both Medicare and Medicaid entitlement.

Value	Definition
00	Eligible is not a Medicare beneficiary
01	Eligible is entitled to Medicare- QMB only
02	Eligible is entitled to Medicare- QMB AND full Medicaid coverage
03	Eligible is entitled to Medicare- SLMB only
04	Eligible is entitled to Medicare- SLMB AND full Medicaid coverage
05	Eligible is entitled to Medicare- QDWI
06	Eligible is entitled to Medicare- Qualifying individuals (1)
07	Eligible is entitled to Medicare- Qualifying individuals (2)
08	Eligible is entitled to Medicare- Other Dual Eligibles
09	Eligible is entitled to Medicare - Reason for Medicaid Eligibility unknown
99	Eligible's Medicare status is unknown.

- **MAINTENANCE-ASSISTANCE-STATUS**: A code indicating an eligible's maintenance assistance status.

Value	Definition
0	Individual was not Eligible for Medicaid this month
1	Receiving Cash or Eligible under section 1931 of the Act
2	Medically Needy
3	Poverty Related
4	Other
5	1115 - Demonstration expansion eligibles
9	Status is unknown

- **PLAN-ID-1, PLAN-ID-2, PLAN-ID-3, PLAN-ID-4**: Fields for specifying up to four Managed Care plan identification numbers under which the eligible individual is covered during the month.

- **PLAN-TYPE-1, PLAN-TYPE-2, PLAN-TYPE-3, PLAN-TYPE-4**: Fields for specifying up to four Managed Care Plan types under which the eligible individual is covered during the month. Values must be consistent with associated PLAN-ID fields.

Value	Definition
00	Individual was not eligible for Medicaid this month
01	Eligible is enrolled in a medical or comprehensive Managed Care Plan this month (e.g. HMO)
02	Eligible is enrolled in a dental Managed Care Plan this month

03 Eligible is enrolled in a behavioral Managed Care Plan this month
04 Eligible is enrolled in a prenatal/delivery Managed Care Plan this month
05 Eligible is enrolled in a long-term care Managed Care Plan this month
06 Program for All-Inclusive Care for the Elderly (PACE)
07 Eligible is enrolled in a primary care case management Managed Care Plan this month
08 Eligible is enrolled in an other Managed Care Plan this month
88 Not applicable, individual is eligible for Medicaid, but is NOT enrolled in a Managed Care Plan this month
99 Eligible's Managed Care Plan status is unknown.

- **RESTRICTED-BENEFITS-FLAG**: A flag that indicates the scope of Medicaid benefits to which an eligible is entitled during each month.

Value	Definition
0	Individual is not eligible for Medicaid during the month
1	Individual is eligible for Medicaid and entitled to the full scope of Medicaid benefits
2	Individual is eligible for Medicaid but only entitled to restricted benefits based on alien status
3	Individual is eligible for Medicaid but only entitled to restricted benefits based on Medicare dual-eligibility status (e.g., QMB, SLMB, QDWI, QI)
4	Individual is eligible for Medicaid but only entitled to restricted benefits to pregnancy-related services
5	Individual is eligible for Medicaid but, for reasons other than alien, dual-eligibility or pregnancy-related status, is only entitled to restricted benefits (e.g., restricted benefits based upon substance abuse, medically needy or other criteria)
9	Individual's benefit restrictions are unknown

Recommendations for Improving Data Quality and Reporting

ENROLLMENT DATA: Successful implementation of the changes planned for the 1999 MSIS will provide researchers with Medicaid Managed Care enrollment data that is more comprehensive. However, before this expanded data can be used, it must undergo a validation process that ensures its completeness and accuracy. To accomplish this, we recommend that HCFA use a phased approach that validates data on a state-by-state basis rather than attempting to validate data for all states simultaneously. The validation strategy should include the following basic elements:

- Perform field checks on the data submitted to ensure its compliance with the 1999 MSIS specifications.
- Once it is confirmed that the data submitted complies with specifications, produce reports by individual Plan that are structured to allow the comparison of 1999 MSIS data to data for the same time period produced by other sources (e.g., MMCER, other state reports).
- Ask each state to correct its MSIS data based on the validation findings.
- Encourage continuous feedback to improve data quality.

ENCOUNTER DATA: Starting 1/1/1999, states will be required to submit Managed Care encounter data to HCFA. During on our discussions with states, we learned that individual states are at very different levels of readiness for collecting encounter data: some states are not receiving any encounter data from Plans; others are receiving incomplete data or are receiving data from some Plans, but not others. Among those states that currently collect encounter data, most don't have procedures in place to verify the completeness or accuracy of that data. For these reasons, many states will be unable to submit encounter data to HCFA until 2000 or beyond.

We recommend that, as states renegotiate contracts with Plans, they incorporate risk adjustment clauses that will give the Plans an economic incentive to submit complete encounter claims. We also recommend that these new contracts include sanctions that can be legally enforced if Plans fail to submit the required data. However, before these steps can be taken, the following issues must be resolved:

- An overall agreement must be reached on which encounter data elements are required (e.g., all of UB92; a subset of UB92).
- HCFA must define MSIS storage requirements and organizational specifications for the additional data to be collected.
- HCFA must evaluate the impact that collection of this new data will have on MSIS.

GENERAL RECOMMENDATION: We recommend that HCFA establish a State

Medicaid focus group that would meet on a regular basis to discuss and resolve common problems relating to the administration and reporting of Medicaid Managed Care data.

The Future of MMCER

Until the 1999 MSIS data has been validated for all states, we must continue to use MMCER to collect Managed Care data. However, once the 1999 MSIS is fully validated, it could be enhanced to generate reports that could expand upon and replace those currently produced by the MMCER.

Lessons Learned

THE VALUE OF PERSONAL CONTACT: The project team discovered that, while conference calls were a source of much valuable information, on-site visits to state offices yielded even more. We recommend personal contact with state staff whenever time and budget allow.

THE NEED FOR IMPROVED COMMUNICATION: While trying to organize and schedule state conferences, it became apparent that information generated by HCFA that is of value to state Medicaid offices does not always reach the right staff members at those offices. A strategy must be developed to improve these lines of communication.

THE NEED FOR COMMON TERMINOLOGY: During our initial contact with each state, a significant amount of time was spent reaching a common understanding of terms. While the changes mandated for the 1999 MSIS may improve this situation, a standardized set of Medicaid Managed Care terminology must be agreed upon.

CMS LIBRARY
3 8095 00005980 4